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## THE PROBLEM OF DEHUMANIZATION

by

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As a way of making clear how the Problem of Dehumanization fits into the total Minnesota Mental Health Program, we will begin by drawing a distinction between the external and internal goals of an organization. The external goal of an organization is its ultimate purpose or mission, usually defined as a certain product or state of affairs which the organization has been designed to bring into being. In our case, for example, the external goal is the prevention, control, and reduction of major bio-psycho-social dysfunction, especially with regard to the behavior clusters commonly known as "mental illness" and "mental retardation." The internal goals of an organization are the specific milestones it must achieve if it is to accomplish its mission. In our case one of the obvious internal goals is the efficient operation of public mental hospitals; this in turn entails the reduction of the problem of the possible dehumanization of hospitalized patients. The advantage of discussing the problem of dehumanization in the context of external-internal goals is that it enables one to emphasize the importance of reducing this problem without creating the impression that we consider this to be our only, or even our ultimate, goal.

But it is a very important goal. The laws emphasize this fact. The basic mental health act of 1949 was predominately concerned with reducing dehumanization. The point emphasized by that act was that the state must bring its mental hospitals up to standards, particularly in the area of the humane treatment of patients. So the problem of dehumanization, while it is not the only internal problem with which we are concerned, seems clearly to be one of the most important ones.

Furthermore, this should be clear: dehumanization is not the exclusive property of mental institutions. Dehumanization cuts across various wide areas of human activity and human affairs. We do not intend to point the finger of scorn or shame at mental institutions or at the people who operate them now or have operated them in the past. We want, instead to do something much more basic: to show how dehumanization develops as the product of certain historical provisions, certain laws, and certain kinds of organizations.

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First of all, what is dehumanization? We define it as the divestment of human capacities and functions, and the process of becoming or the state of being less than a man. We could debate considerably on the philosophical aspect of this definition, asking ourselves what we mean by the word human, or by human nature, and we could thereby add our voices to the many thousands and millions of words which have been spoken on this subject since man became aware of himself. Such philosophical questions are important, but they cannot be adequately treated in a short paper. All we can do is to clarify what is meant by showing some instances or examples of dehumanization.

Where is dehumanization found? Dehumanization is not the exclusive property of mental institutions. It can also occur in the work of county welfare workers when they deal with families for whom they must find proper homes or with children who must be placed with foster families, or with persons who must be placed in proper boarding and nursing homes. Dehumanization is a problem for the people who operate such nursing homes; it is a problem for the administration, medical, nursing and other staff in TB sanatoria; it is a problem for correctional institutions; for Indian reservations; for urban planners and for those who work in slums. The much debated National Service Corps, or Domestic Peace Corps as it is sometimes called, addresses itself essentially to the problem of dehumanization. In short, this problem is of concern to anyone who manages or is responsible for a situation which involves the care, maintenance, support, or supervision of other people who are living essentially in a dependent situation. Dehumanization may occur in any situation where one person is responsible for making the day-by-day decisions regarding the comfort and welfare of other persons.

How does dehumanization come about? For information on this subject we have turned to a book entitled Asylums written by Erving Goffman, a sociologist. Goffman is not the only one who has studied this problem, but his contribution has been unique because as a sociologist and as an outsider he has had no axe to grind with mental hospital personnel and so has been able to observe conditions in mental hospitals with complete detachment. Perhaps Goffman's candor can be traced to the fact that he has approached this problem not to find out what is wrong with mental hospitals, but simply to describe what he sees. And what he sees is that mental hospitals have many features in common with what he calls "total institutions", which are organizations that seem to make a specialty of dehumanization.

What are some of the features of the total institution according to Goffman?

The first feature of total institutions is that they are all-encompassing. The individual's entire life is spent within one set of boundaries, usually specific geographical boundaries. He works, sleeps, breathes, plays, lives, in this one setting. Obviously this feature is to be found not only in mental hospitals but also in boarding schools, monasteries, ships at sea, jails and prisons, migrant labor camps, Indian reservations, and military establishments, just to name a few.

Another feature of total institutions is the fact that a small group controls a larger group. In a boarding school a small group of masters supposedly controls a much larger group of students; in a prison a small group of gaolers controls a much larger group of inmates; in a mental institution a small group of staff personnel controls a much larger group of patients; and in an army a small group of officers controls a much larger group of enlisted men. This centralization of control partly accounts for the fact that total institutions dehumanize their inmates by severely limiting their capacity for self-determination.

The total institution has a rationale: There is some kind of thesis or idea that becomes the working hypothesis for the institution. Further, this tends to have something to do with producing a career, with "making someone over". For example, the rationale of the boot camp is to take a group of nitnits off the streets, out of the bars and drugstores and the drag races and wherever they may be — colleges, maybe — and to make soldiers out of them. The rationale of the entire organization is based on producing something different; producing — to anticipate the point — a unit of work, in this case a soldier. The monastery has the rationale of taking someone with worldly connections and making him into a true and complete servant of God. The boarding school has the rationale of taking adolescents and making gentlemen out of them. And so it goes.

This leads to the question, What is the rationale of the mental institution? We talk about treatment, about the fact that everything that goes on in a mental hospital is part of the treatment, as though to suggest that the hospital takes over the patient's particular mental illness and makes something better out of him. Sometimes it seems that, in a crazy way, the institution rather actually makes the person into a mental patient and produces for him the career of a Mental Patient. This is a very interesting idea — a disturbing one, of course — but a useful one if we are talking about what actually happens in mental hospitals and what is the end product. We now have reason to believe that a lot of the things we have done because we did not know any better or because we did not know how else to do it, tend to produce a career mental patient.

Another feature of the total institution is that the inmate's entire life is spent within its boundaries. This is in very sharp contrast to what we refer to as normal life. Usually one lives in one place and works somewhere else and takes his pleasures somewhere else again. In the total institutions this is not the case: everything takes place in one setting. Furthermore, there is a kind of transferability. Normally one's work supervisor, if displeased with one's work performance, does not ask the employee's family to extend the discipline into the home setting. But this prohibition does not obtain in a total institution. The patient who goofs at the laundry is still punished when he gets back to the ward. We will talk more about the punishment and reward aspect of the total institution later on. For the moment, let us note that the punishment is transferable.

One of the aspects of Communism that is so repulsive to us is that political or national the entire state is a total institution. A beautiful example of this is that the public official in Communist Russia is rewarded or punished not only by being fired from his job, although this may happen, but in other ways which would carry over into the living area. A perfect example is Yuri Gagarin who, when he returned from his first manned space flight, was rewarded by being moved to a larger and classier apartment. The government controls the housing as they do many other things. This would be really unthinkable in our country. We might give John Glenn a Congressional Medal and honor him with parties and with all kinds of gifts, but it would be inconceivable that the President would somehow arrange to have him moved to a better house. His commanding officer conceivably might do this in the total institutional context of the military post where he lives, but as a nation we do not operate this way.

The next important feature of total institutions is what Goffman calls "people work". This again is related to the rationale, to the matter of producing a career: for example taking a plowboy and making a soldier out of him, a unit, a cog in a machine. "People work" consists in processing units, applying grievous dehumanization in order to make good ultimate form. An outstanding example of this is what came to light in the Eichman trials, where this was actually the jargon that was used: "We processed so many units in the month of July, 1943." We see many examples of this in our institutions when we talk about numbers, about categories. In state central offices we do this. We talk about having so many less patients or so many less units to care for than we had a month ago, or so many more, whatever the case may be.

Another feature is the process of mortification, and we can find many examples of this. It relates in part to the "people work" idea, because it is the process by which we mortify the individual until he becomes a unit. Mortification relates also to the rationale. The monastic system, whether we are talking about Christian monasteries or Buddhist, employs mortification to eliminate worldly commitments as rapidly as possible. Boot camps do the same thing. The story was told, during World War II, that at one Marine boot camp as the recruits got off the train, still in their civvies, one of the drill sergeants lined them up and ordered them to stand at attention while he had his eight-year-old daughter rail at them in a most vile fashion, calling them all sorts of horrible and humiliating names. Mortification processes similar to this can be found in many total institutions. Fraternity hazings make a person a working unit of the organization by subjecting him to certain rituals which are mortifying in nature. In boarding schools this is not uncommon. The new boys wear silly hats, do silly errands, perhaps carry bricks around, all of this presumably designed to make them "good boys" in this particular institutional setting.

We have abundant examples of mortification taking place day by day in our mental institutions, things which maybe started because

we didn't know any better, or because there were so few people at the time, but which now persist for no reason whatever. All of you have heard the complaints from patients who have come in from very good homes, perfectly trained, well-dressed, well-groomed; they don't smell; they don't appear to have lice; and yet they are forced to take a bath, to remove their clothing, and to put on state clothing. Recently a patient was transferred from one institution to another and wanted badly to go back. One of his reasons for wanting to return was that when he had come to the second institution he had had to surrender his own clothes and had been given state clothes — he had even had to give up his fountain pen. Perhaps because a patient hurt himself with a fountain pen back in 1919 we still take away all fountain pens; perhaps because once a patient hung himself with a belt, we remove all belts. One point to note is that these regulations get wound in with the rationale. When asked why we are doing this or that we can say, "Because it is part of the treatment program. It's something that you must do because this is the only way you can get better."

The next major feature of total institutions is the system of reward and punishment. I think in some ways the traditional process of moving patients from the more convalescent or treatment-oriented wards into the more regressed wards is in some ways related to punishment. We may use this deliberately, saying, "If you don't go to the movies or don't go to work, or if you don't participate in such and such an activity, you'll have to go back to the other ward." It is like sending a child to his room; it is a way of punishment. But we rationalize this by saying, "He is no longer able to benefit from the treatment program in this ward or in this building or in this hospital, and therefore he must go to this other building, or ward, or hospital." But, to translate, this often means that he goofed and that this is his punishment. The reward, of course, works in the other direction: long-term patients who have become pensioners in the institution somehow are allowed to gravitate to a place where they will have special privileges. Maybe they get to be a messenger and they can roam the grounds; maybe they can earn a little money because they have the car washing concession. If the patient goofs, which we translate as, "He becomes too ill to handle this responsibility," then he goes back. Now these examples no doubt are irritating. Hospital personnel might reply, "How else are we going to run it?" Maybe there are no other ways to run it. But we must at least examine these things, since they go on day by day in our institutions.

A subtle feature of the total institution is brought out forcefully in George Orwell's essay, "Such, such were the joys . . ."

where he describes English boarding school life in the early decades of this century. He refers to the pervasive feeling of guilt, the communication by Staff in a multitude of ways that somehow Inmate is wrong, unworthy, undeserving of all the attention he is getting. Further, the reasons for this, or what can be done to improve, are never quite made clear. Existential philosophers and novelists, have dealt also with this theme. Kafka: "Guilt is never to be doubted."

Finally, total institutions are self-perpetuating. Practices become fixed in the tradition, and the rationale of the organization develops around them and perpetuates them.

Why are we questioning this process? Because if we do nothing else we can at least look at some of these things objectively and honestly.

In this process of self-questioning we refer at the outset to Goffman's specific observations of dehumanizing practices as specified for the mental hospital setting. For example: Are the patients regarded as units for processing? Do we seem to indicate indifference to the physical integrity of the patient, including such things as restraint and seclusion? Do we subject the patient to the sickness-treatment rationale of the institution? Do we provoke a defensive response, then attack that response as a symptom of the illness? For example, do we tease or nag the patient until he reacts and then say, "Aha! There's your mental illness again." Do we allow the patient face-saving reactive expressions? Do we interpret all actions, even those normally considered indifferent, as signs of illness? (The psychiatrist probably has been mainly responsible for causing us to believe that everything we do is somehow a defense or a sign of neurosis, a sign of dementia.) Do we perpetuate the diagnosis as a permanent badge, so that once a patient is labeled schizophrenic he is always a schizophrenic? We have had some bitter experience in overcoming the problem of getting the patient back into the community as a result of this tendency of ours to attach a permanent diagnostic badge to the patient. The medical and psychiatric professions are mainly to blame for this practice. In one state institution the whole discussion in a staff meeting was for a long time devoted to trying to determine whether a particular patient was an "old schizophrenic" or a "young schizophrenic". Once it was determined whether he was "old" or "young", he was given his badge and permanently labeled schizophrenic. Thereafter, presumably, he would not have to be thought of as a person at all, but simply as a diagnostic type, as a thing bearing a label.

Goffman has also made observations of the process by which patients adapt to institutional life. Some of these processes are considered bad in terms of the privilege system: for instance, withdrawal or regression, that is, clamming up; another is intransigency, which means fighting the system, or bucking back. Reactions which are considered good in terms of the privilege system are more interesting and a little more subtle. Goffman mentions colonization where the patient settles down in the institution, finds a home there, builds a little niche for himself with his collection of odds and ends, and succeeds in making some sort of free world for himself with the limited materials available. Another "good" adaptation is conversion, where the patient accepts the view that he is no good, and that it is therefore proper and only correct that he should be in this place and be subject to degrading disciplines.

"Playing it cool" is the process of getting along while at the same time harboring underlying hostilities to the system. "Immunization" is an interesting process which occurs with persons who have been in this kind of setting for so many years -- in orphanages, boarding homes, hospitals, schools for the retarded, or jails -- that they have become immune to institutional life and do not mind how they are treated. "Identification" is the process through which the patient becomes the "company spy", the stoolie, the guy who rats on his associates.

Here are some comments which patients themselves have written concerning dehumanizing influences in their hospitals. In March, 1963, a questionnaire was sent from the state central office to all patients in hospitals for the mentally ill asking how they felt about the treatment program and inviting them to communicate what they had to say directly to "the top", so to speak. In some hospitals as few as  $1\frac{1}{2}\%$  of the total patient population made responses, whereas in another hospital something like 40% of the patients responded. Even this fact was significant, since one of the things we wanted to determine was the degree to which a two-way communication system was actually operating between our office and the patients. But our main interest was in finding out what the patient would tell us about what we in turn should tell the public regarding Minnesota's mental health program. You might be interested to know, for example, that the patients themselves are as passionately aware as we are of the need for more staff. If the legislators could read these comments from patients they would be much more convinced of the need. We were not searching for complaints. Nevertheless, we got them, since this was interpreted by many patients as their chance to say something. It is only fair to mention that we are quoting here only the negative comments, and not the others, because the negative comments have more to do with the problem of dehumanization.

One patient talks about student nurses coming, and how this has made a great difference in the hospital:

"The nurses help a great deal in drawing some of the patients out. They seem more like human beings and less like robots going through the day either sleeping or scared of making a mistake for lack of anything else to do."

Another patient:

"It seems that when a patient like myself is brought to one of these hospitals in a state of delusion or hallucination or

what have you, the staff is oh so anxious to do something about it. First, observation; second, the shock treatment; plus all the attention of student nurses, doctors, registered nurses, aides, etc. Then, when the patient has reached a plateau and begins to get more self-sustaining, everything is dropped. He is put into one of the other cottages, given work, and damn near forgotten. He's supposed to do the rest all by his little ol' self."

Another patient's statement emphasizes the dehumanizing effect of allowing a communication system to break down:

"Dr. so-and-so gave me a tranquilizer without even glancing at me or seeing the condition I was in. I was told in a letter one day when I changed to such-and-such a ward for over three months before returning to this other cottage, that the hospital staff would contact me when the end of the transfer would occur. No one had contacted me after four months and I was under severe tension."

Here is a disturbing statement:

"It concerns me that some of the patients who are handling food should not be working with infectious sores on their arms, etc."

And (another patient):

"When they pass the medicine they don't use clean water glasses. Even if there is a little bit of water left in a glass the nurses order a patient to empty other glasses with a little water in them until their glass is filled. They don't change sheets in the sick room, instead they just remake the wet ones. At least when it was my chance to get a bed in there, that's what they did."

It would be hard to ascertain whether this is true or not. It is of course impossible to check each specific complaint. But maybe in the press of business, or for other reasons, these things do happen.

"Too many shock treatments."

"Shock treatments of any kind are a great shock to the patients."

"My head was operated on without my consent or knowledge."



Here is one pertaining to the use of seclusion and restraint, the point being that he interprets the use of restraint and seclusion as a punishment and not in any sense a process of therapy:

"I'd like to complain about our security. A little room where we're put when bad."

Notice that this patient doesn't say, "When we become disturbed mentally or are acting out our delusional systems," but only, "when we are bad".

Another patient says:

"I don't think our relatives realize all a patient has to go through. It seems they could do a lot more to help a patient get well if they could take an interest in them and treat them more like human beings. Many of the patients have not seen their relatives or heard from them in years. It's as though they're brought there and left for someone else to worry about, and forgotten there. It leaves the patients with a sense of insecurity and helplessness."

Here is another interesting one. Here this patient is talking about the career of Mental Patient; after you're here a little while you become a career patient and you begin hearing voices:

"There's no need for rash decisions regarding mental illness on the part of juries. Simple mental conditions after years of probing seem to improve. If a simple thing like hearing voices occurs, this is easily done away with with a few weeks of pills. These diseases are not serious unless a person is actually committed for long periods of time, when of a sudden, it is almost a duty to hear voices again. And then the question is, would the occasional hearing of voices that are not of the annoying type be very serious?"

Now, you can make of these complaints what you will. It looks as if the kinds of things we have been talking about are things that are experienced by the patients. The patients do in actual fact feel that they are being degraded. They have the sense of being handled as mere units in a batch.

In conclusion, we should be aware of, look for, and analyze the structure and the system in which dehumanization occurs. When we do, we can realize that this is a process which is taking place day by day, not necessarily because anyone has willed it or because we are bad people, but because somehow in the structure of the organization this is what has developed.

Here are several questions: What can we do about dehumanization? One answer usually obtained is 'get more staff'. Assume we are not going to; then our task is to do something about the problem with the facilities at hand. What programs or projects or methods might there be for handling or dealing with this problem? Each of you should apply this check. Finally, each institution should continue to study this problem with its staff at every department level so that everyone in the institution will have a chance to acquaint himself with the problem of dehumanization. Let it be said again: This is one of the key problems with which we have to deal.

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